

County of Los Angeles – Department of Mental Health
Local Mental Health Plan
REQUEST FOR CHANGE OF PROVIDER
CONFIDENTIAL

To request a change in your current provider, please submit this form to the Program Manager's office. Every effort will be made to accommodate your request. You will receive a decision within 10 working days. If you are a Medi-Cal beneficiary seeing a private provider in the community who is not part of a county operated or county contracted program, call the Beneficiary Services Program in the Patients' Rights Office at 800-700-9996 or 213-738-4949. The Mental Health Plan cannot guarantee that your provider will be changed. If you do not receive a decision on your request within 10 working days or you disagree with the decision, you may file a formal grievance.

SECTION 1 CURRENT PROVIDER INFORMATION (Clients please fill out Section 1 & 2 ONLY)

DATE: _____ SERVICE LOCATION: _____

PROVIDER NAME: _____

SECTION 2 BENEFICIARY/CLIENT INFORMATION

Client Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ /ZipCode: _____

Phone Number: _____

1. I am requesting a change in:
- ☐ Service Staff ☐ Medical Staff ☐ Program

2. Please describe the reason(s) for requesting a change. (This information is optional)

3. Have you discussed your concerns with your current provider?
- ☐ Yes (Please describe what you have done to try to resolve the problem)

☐ No

I understand that I will be contacted about this request within 10 working days.

I prefer to be contacted by: Mail ☐ Telephone ☐ Email ☐

Today's Date: _____

Signature of Person making request _____

Parent/Guardian Signature if request is by/for a child or youth: _____

SECTION 3**AUTHORIZED COUNTY USE ONLY****Clinical Data**

DSM-IV

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Medications: Specify dosage and frequency: _____

REVIEWED BY: _____

DATE: _____

RECOMMENDATION: _____

Referral To: _____

Notified: _____

Date: _____

Appointment: _____

Beneficiary/Client Contacted: _____

RFCOP2
LA

This confidential information is provided to you in accordance with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by Law. Destruction of this information is required after the stated purpose of the original request is fulfilled

Name _____ MIS# _____

Facility/Practitioner: _____

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